# EXHIBIT 6

THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

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| IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION | MDL DOCKET NO. 01CV12257-PBS |
| ********** | FEBRUARY 28, 2006 |
| THIS DOCUMENT RELATES TO: ALL ACTIONS | VOLUME: IV<br>PAGES: 905-1168 |

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C O N F I D E N T I A L

CONTINUED VIDEOTAPED DEPOSITION OF RAYMOND S. HARTMAN, PH.D., called as a witness by and on behalf of the Defendants, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Dwyer & Collora, LLP, 600 Atlantic Avenue, Boston, Massachusetts, on Tuesday, 28 February, 2006, commencing at 9:33 a.m.

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the marketplace for the drugs? Answer: Yes."
A. Okay. Can I --
Q. Does that affect your opinion that there's no evidence that payers expected that the spreads for generics and multi-source would be any different than the spreads for single source?
A. I'm -- I'm looking back to see the context of whether this is self-administered, whether this is all drugs, whether this is focused on physician-administered per se. (Witness reviews document.) So, so far I'm seeing that these are all self-administered drugs that they're talking about. I'm seeing pharmacies and the use of PBMs and all of which did affect MAC pricing and was more aggressive for the self-administered drugs.
So, I'm seeing your -- the citations that you're -- the quotes that you're getting at are really not even directed to our group of drugs since PBMs generally are uninvolved with -- with physician-administered drugs and the pharmacies are generally uninvolved with physician-administered drugs.

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So, I don't know what this tells me about what -- some knowledge about self-administered drugs, because, as I said, that's a much different kettle of fish than has been recognized by this court and recognized generally by students of the -- of the industry.
Q. Well, the witness in that answer doesn't distinguish between self-administered drugs and physician-administered drugs, does he?
A. Well, if you go back, I mean, that's why I went back to -- to the preceding pages, and I went back to Page 120 and he -- they're talking about -- you had discussions with other individuals at Tufts at that time regarding the fact that AWP was artificial. And then the answer -- "we had concerns with regards to AWP as the price in which we reimbursed for drugs at the retail pharmacy and encouraged our physicians to utilize generics."
Now I see that as pharmacy-related stimuli to physicians to move drugs, and then the mention of the PBMs is on Page 125, and all of this is in the context of PBMs and pharmacy decisions, and I -- so

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I -- I don't see where this -- I mean, it -- you may be able to contextually relate it prior to Page 121. And this set of Q&A as I see it just focused on self-administered.
Q. So, are you now changing your testimony and saying that a self-administered drug would not be a good comparator for a physician-administered drug?
A. No.
MR. NOTARGIACOMO: Objection.
A. I looked at self-administered drugs of innovator drugs, single source unique drugs. We're talking about generic competition in self-administered drugs. That's not -- that's orthogonal to my opinions that I've put forward.
Q. Would you agree with me that after the introduction of generic drugs the prices of generic drugs follow a predictable trajectory from the pre-generic launch brand name price toward variable production cost as more generics come into the market?
A. That sounds like a -- like a -- a very-

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well crafted sentence.
Q. So you would agree with that sentence.
A. I would. But I would -- I would qualify it for self-administered drugs. There's not much evidence available for physician-administered drugs that I am aware of or that Doctor Berndt is aware of to make characterizations that I would -- that I -- for which I agree with that.
Q. Certainly payers who purchase drugs directly from manufacturers would be knowledgeable about spread-based competition, depending on the extent to which there are alternatives for a particular drug. Would you agree?
A. And are we -- to try and give specificity to this, are we talking to -- about staff model HMOs, something like Kaiser, or is that what you're asking about, someone like Kaiser?
Q. Sure.
A. Yes. They would -- they would have more information, and I would point out that we've excluded -- I've excluded those sales to those entities from the damage analysis.

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Q. Well, those entities are also third-party payers, correct?
A. They're third -- a Kaiser is both -- deals with insurance and deals with the administration of the drug, and they were not considered part of the class as being indirect -- indirect payers and the -- as I have -- when -- when we were doing the analysis of the units that were subject to damages, sales to those types of entities, I asked my staff to exclude, and they did the best they could given the interpretation of the customer names and the classes of trade codes that were found in Defendant's data.
Q. So, let me make sure I understand what you're saying. You understand that many third-party payers also own their own HMOs, correct?
A. I know that -- that some third-party payers are affiliated with H -- with -- do you mean PBMs or what --
Q. No. I'm talking about HMOs or hospitals.
A. The precise affil -- set of affiliations between payers and how many are integrated with

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hospital, I have not done sufficient analysis of to really comment on.
Q. Well, a payer that owns an HMO or a hospital and purchases drugs directly from a manufacturer would know about spread-based competition, correct?
A. A third-party payer that -- one of whose subsidiaries buys drugs directly hopefully should be informed by those subsidiaries to the --
Q. Okay. So, in the case of Kaiser Permanente or other payers like that, you're not simply excluding the sales to the HMO from your damage calculation. You're excluding all reimbursements made by that payer, correct?
A. What I have done in my declaration and asked my staff to implement in the damage calculation is to identify those sales -- unit sales -- to clinics, to oncology groups, to GPOs that are unaffiliated with payers, that are essentially providers.
Q. So --
A. That are -- that are then going to submit

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the reimburse -- claims for reimbursement to third-party payers.
Q. So, you only exclude from your damage calculation then the sales to the provider operation of that payer. You don't exclude all reimbursements by that payer, correct?
A. I'm not quite sure I understand. If -- if a given -- if -- say Kaiser is one example. We exclude all sales to Kaiser and we exclude all sales to any hospital, even though we know some of them will be subject to reimbursement by third-party payers in an outpatient context. It -- precisely to avoid some issues of -- to be conservative.
Q. Well, let's take Blue Cross Blue Shield of Massachusetts. Did you understand that for a period of time Blue Cross Blue Shield of Massachusetts owned an HMO?
A. I know there was an issue. It is my recollection that there was an issue about -- about that and which years it -- that was relevant, but I forget the details at the moment.
Q. So, assuming your staff carried out your

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instructions properly and they had adequate information, they should have excluded from the damage calculation the sales to that HMO, correct?
A. If there were sales to what we've classified and -- and I asked the staff to -- as -- as staff model HMOs like a Kaiser, they attempted to do so as best they could with the -- with the names that -- the data that was given to us.
Q. And the reason you excluded those sales is because, as a direct purchaser from a manufacturer, that HMO would know about the spreads. In fact, that HMO would be one of the entities out there getting the discounts that create the spreads, correct?
A. The -- the guiding decision, and I'm looking back here at the class definition, was to focus, in my recollection, it's not stated here specifically, on indirect payers. And so by definition, a Kaiser is a direct purchaser and -- in a staff model HMO. I think correct.
Now, I don't see that as being stated here within this Subclass. And so I should perhaps go

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back and look at the earlier complaint to see whether my understanding is consistent with that.
Q. Isn't it inconsistent to exclude the sales to the HMO but include all of the reimbursements by the same company? In other words, let's take Blue Cross Blue Shield of Massachusetts. Let's take a particular drug. My client, BMS, Vepesid, and let's assume that BMS sold a million dollars worth of Vepesid to the Blue Cross Blue Shield of Massachusetts HMO and Blue Cross Blue Shield of Massachusetts also reimbursed providers for $100 million in sales of Vepesid. You would exclude the million dollars paid by the HMO from your calculation, but you would include the $100 million paid as a third-party payer in your damage calculation, correct?
MR. NOTARGIACOMO: Objection.
A. I would -- in situations of that sort -- you've -- you've identified one more type of payer that has some information -- maybe it's more, maybe it's less than what's -- what appears in Medicare, but the fact that it its reimbursement schedules are

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based on revealed negotiations from an earlier period of time and a revealed understanding of what the relationship between AWP and transactions costs were, and there is some information here that that's to Blue Cross Blue Shield of Massachusetts but that they haven't acted on it, it means that institutionally they have yet to assimilate that and -- and be able to have moved to insulate themselves from the -- the abuse alleged in the matter.
Q. Let's take some additional examples of this.
MR. EDWARDS: What I want to do is mark as Exhibit Hartman 048 an excerpt from the BMS charge-back database for Customer Code 26.
(Excerpt marked Exhibit Hartman 048.)
Q. Did you exclude sales to Customer Code 26 from your damage calculation?
A. This is for BMS?
Q. Right.
A. (Witness reviews document.) Yes, I did.
Q. And Customer Code 26 would include CIGNA, HIP of greater New York --

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A. Well it's CIGNA pharmacies in Los Alamitos, California. It's -- in Arizona and Florida. Are you saying CIGNA overall or.
Q. Well three of the CIGNA plans.
A. Okay, right.
Q. Right?
A. Right.
Q. Lots of HIP --
A. Right.
Q. -- entities. Do you want to go through them all?
A. No. No. No. I'm --
Q. Okay.
A. The --
Q. And indeed you've got HMO Blue at GMA, correct?
A. Hey.
Q. And Humana?
A. We made it. God. We're right there with --
Q. And Kaiser?
A. Right. Can I keep this?

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Q. Sure.
A. No, I'm just kidding.
Q. You exclude direct sales to all of these entities from your damage calculation, but you don't exclude these entities from the third-party payer class, correct?
A. We exclude certainly the direct sales and then the charge-back related data, but that is true to the extent that there are indirect reimbursements to these entities, they are included.
Q. You include them in the class, even though they were obviously knowledgeable about the spreads?
MR. NOTARGIACOMO: Objection.
A. Well, it --
MR. NOTARGIACOMO: You can answer the question.
A. There's -- they purchased these drugs and to the extent -- I can't -- until I see that they have either responded to it with the contract change, such as MAC, or they've responded to it institutionally and said we're going to just ignore this, I have no information that whatever kind of --

# EXHIBIT 7

THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

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|---|---|
| IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION | MDL DOCKET NO. 01CV12257-PBS |
| ********** | DEPOSITION OF |
| THIS DOCUMENT RELATES TO: ALL ACTIONS | JOHN M. KILLION JANUARY 6, 2006 |

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H I G H L Y C O N F I D E N T I A L

DEPOSITION of JOHN M. KILLION, a witness called on behalf of the Defendant Johnson & Johnson pursuant to the Federal Rules of Civil Procedure, before Judith McGovern Williams, Certified Shorthand Reporter, Registered Professional Reporter, Certified Realtime Reporter, Certified LiveNote Reporter, and Notary Public in and for the Commonwealth of Massachusetts, at the offices of Robins, Kaplan, Miller & Ciresi, L.L.P., 800 Boylston Street, Boston, Massachusetts 02199, on Friday, January 6, 2006, commencing at 9:41 a.m.

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PROCEEDINGS

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JOHN M. KILLION, first having been duly sworn, testified as follows in answer to direct examination by MR. HAAS:

- - -

Q. Please state your name for the record.
A. John Killion.
Q. Mr. Killion, are you currently employed?
A. Yes, I am.
Q. By whom?
A. Blue Cross/Blue Shield of Massachusetts.
Q. What is your current position?
A. I am senior director, ancillary services.
Q. What is ancillary services?
A. Responsibility for contracting with all provider types with the exception of acute care hospitals and physicians, so I have responsibility for contracting with provider

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types, such as ambulance, radiology, laboratory, physical therapy, occupational therapy, speech therapy, approximately a little over 40 or so different provider types other than M.D.s or acute care hospitals.
Q. Does any of your contracting with these various ancillary entities involve contracting for the reimbursement of physician-administered drugs?
A. No.
Q. Do you have an understanding that physician-administered drugs are the drugs at issue?
A. Yes.
Q. Who at Blue Cross/Blue Shield of Massachusetts has the analogous position to yours but that is in charge of reimbursement of physician-administered drugs?
A. That would be my peer, Sheila Cizauskas, who is the senior director for hospital physician contracting.
Q. I am sorry. I didn't catch that name?

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A. C-I-Z-A-U-S-K-A-S.
Q. What was her first name?
A. Sheila.
MR. HAAS: Off the record.
(Discussion off the record.)
MR. HAAS: We again had our morning difficulties with the call-in number, so we just started, just, about five minutes into it. So we are just going to continue with the background of the witness.
Q. What is Ms. Cizauskas' title?
A. She is senior director for hospital contracting.
Q. Is she also responsible for contracting with physician groups and physicians?
A. She is, along with one other individual.
Q. Who is that other individual?
A. Steve Fox.
Q. What is Mr. Fox's title?
A. Senior director, provider relations.
Q. Who do you report to?

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A. Deb Devaux.
Q. What is her title?
A. Senior vice president, contracting.
Q. In your current --
MR. HAAS: Withdraw that question.
Q. When did you start at Blue Cross/Blue Shield of Massachusetts?
A. 2001.
Q. What was your initial position?
A. Director, ancillary services.
Q. At any time from 2001 to the current time frame, have you had any responsibilities with respect to the negotiation or contracting of reimbursement with physicians for drugs administered to Blue Cross/Blue Shield of Massachusetts members?
A. Can you repeat that again?
Q. Sure. At any time from 2001 to today - -
A. Yes.
Q. -- have you had any responsibilities with respect to contracting for the reimbursement

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or the negotiation of reimbursement with physicians for drugs that have been administered to Blue Cross/Blue Shield of Massachusetts members?
A. Not directly.
Q. When you say "not directly," have you been indirectly involved in the contracting or negotiation of reimbursement for physician-administered drugs?
A. Yes.
Q. What is the indirect role that you have had?
A. In 2003, responsibility for implementation of specialty pharmacy programs.
Q. Does Blue Cross/Blue Shield of Massachusetts have a specialty pharmacy program that is used to supply drugs to physicians for administration of drugs to the patients -- to the members of Blue Cross/Blue Shield of Massachusetts?
A. Can you repeat that again?
Q. Sure. Does Blue Cross/Blue Shield of

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Massachusetts have a specialty pharmacy program that involves the provision of drugs to physicians for the administration to members of Blue Cross/Blue Shield of Massachusetts?
A. We have a specialty pharmacy program. It doesn't provide the drugs directly to the physicians. No.
Q. Do you have a specialty pharmacy program that involves at all the supply of drugs, either to the physician or to the patient, which are thereafter administered under the supervision of physicians or their staff?
A. Yes, we do.
Q. Okay. When was that program implemented?
A. In 2004 and 2005.
Q. What is the name of that program?
A. It is our specialty pharmacy program.
Q. Does Blue Cross/Blue Shield of Massachusetts have its own specialty pharmacy, or does it contract with a specialty pharmacy?
A. Contract.

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Q. What is the specialty pharmacy or pharmacies?
A. Priority Healthcare.
Q. Any other one?
A. Caremark.
Q. Any others?
A. No.
Q. Is there a division of Priority Healthcare that is actually the specialty pharmacy?
A. Yes.
Q. Which division?
A. Priority Healthcare is a specialty pharmacy.
Q. A physicians' supply company; right?
A. It is a specialty pharmacy company that supplies high-cost injectables.
Q. Right. Is there a particular division of Priority Healthcare that you work with, or is it just the Priority entity?
A. Priority.
MR. SULLIVAN: Erik, before we got

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started, maybe it was due to the telephone or whatnot, I just want to make sure that the entire transcript is designated as highly confidential.
MR. HAAS: Sure.
BY MR. HAAS:
Q. Aside from your involvement with the implementation of the specialty pharmacy program you just described, have you had any other involvement, directly or indirectly, with the contracting for the reimbursement of physician-administered drugs or the negotiation of such contracts?
A. No.
Q. When did you switch positions from director of ancillary contracting to senior director?
A. I didn't -- oh, switch positions from? I am sorry. Director of ancillary to senior director?
Q. Yes.
A. That was in late 2004, I believe.
Q. So you held your position as the

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A. I have not graduated yet from Suffolk.
Q. When did you start taking courses at Suffolk?
A. Let's see. Approximately 15 years ago, I would say.
Q. When was the last time you took a course at Suffolk?
A. Thirteen years ago.
Q. So it is fair to say you didn't complete your degree?
A. That's correct.
Q. Have you taken any other courses or studies involving the healthcare system since then?
A. No.
Q. Have you taken any training or courses involving prescription drugs?
A. No.
Q. Please review for the record your employment history after graduating from Providence in 1985.
A. I actually worked a year at Blue

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Cross/Blue Shield of Massachusetts.
Q. What was your position at that time?
A. I was in the benefit department.
Q. And when you say "benefit department," what was that? What were the responsibilities of that department?
A. Responding to member-related benefit issues.
Q. So you held that position from 1985 to 1986?
A. That's correct.
Q. What did you do next?
A. I left Blue Cross/Blue Shield of Massachusetts and went to Tufts Health Plan.
Q. What was your position at Tufts?
A. I was a manage in the ancillary services department.
Q. What were your responsibilities as a manager in the ancillary services department?
A. Contracting with the ancillary network.
Q. Did any of that responsibility or work involve contracting for the reimbursement of

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physician-administered drugs?
A. No.
Q. How long did you hold that position?
A. I held that position for approximately until '94, '95.
Q. During your time at Tufts from 1986 to 1994 or '95, did you gain an understanding as to the methodologies Tufts used to reimburse physicians for drugs administered to its members?
A. Can you rephrase -- say that time period again? I am sorry.
Q. You said 1986 to 1994 or '95 while you were a manager in the ancillary services department?
A. Yes.
Q. Did you gain an understanding how Tufts reimbursed physicians for drugs administered to its members?
A. No, I did not.
Q. What did you do next?
A. I became the manager of pharmacy operations at Tufts.

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Q. What were your responsibilities in that role?
A. I was responsible for managing the relationship with our pharmacy benefit manager.
Q. Who was the PBM at the time?
A. It was PCS, Prescription Card Services.
Q. And when you say "managing the relationship," what in particular did you do?
A. Contract responsibility and program development.
Q. In connection with your work as the manager of the pharmacy operations of Tufts, were you involved at all with the contracting of pharmacies themselves?
A. No.
Q. Is it fair to say that Tufts utilized the network of PCS?
A. That's correct.
Q. So your contract was with PCS?
A. Correct.
Q. When you said -- when you referred to program development, what programs are you

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A. Correct.
Q. You have no understanding as to how in particular Medicare derived the exact numbers in its fee schedule; right?
A. Off of AWP.
Q. What is your basis for the understanding of that point?
A. That AWP is the -- or AWP is the industry standard in regards to reimbursement for drugs.
Q. Do you have an understanding of what the actual calculation was that Medicare used to derive the numbers in its fee schedule?
A. Not directly, no.
Q. Do you have of any AWP they used?
A. I believe it was Redbook.
Q. Do you have an understanding of whether all the carriers followed the same process in reimbursing for physician-administered drugs under Medicare?
A. I'm not aware if they all followed the same practice or not.

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Q. How in 2003-2004 did you obtain an understanding as to how Blue Cross/Blue Shield of Massachusetts reimbursed for physician-administered drugs on a fee-for- service basis?
A. Through the specialty pharmacy committee that was put in place.
Q. Who was on the specialty pharmacy committee?
A. I don't recall all the individuals, but it was a cross-section of various individuals from different departments, including pharmacy, clinical, medical directors, people on my staff, member services.
Q. Okay. If you could for me for the record list the individuals that you do recall and their titles.
A. Pam Mortland.
Q. What was her title?
A. I believe she was manager of pharmacy operations.
Q. Who else?
A. Joe Guianta, G-U-I-A-N-T-A.

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Q. What was his position?
A. Pharmacy analyst.
Q. Who else?
A. Matt Connell.
Q. What was his position?
A. Director of pharmacy operations; Jan Cook, medical director; Laurie Liscio, manager, ancillary services; Janis Pochini, contract manager, ancillary; David Lynch, pharmacy analyst; Tim Fitzgibbons, analyst in the actuary department; Paula Choquette, clinical case manager; Heather Cooke, contract specialist in the ancillary department; while not a full-time member, Karen Jackson -- Wells-Jackson, and I don't know her exact role, but she worked in pharmacy.
Q. Was there anyone from provider reimbursement or provider contracting?
A. Provider reimbursement, I believe Mike Mulrey participated in some of the meetings.
Q. Anybody else from the provider side?
A. Not that I recall.

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Q. Was it common at Blue Cross/Blue Shield of Massachusetts to have these cross- functional committees?
A. Very common.
Q. So it was common to have people from the pharmacy side of the business with people on the provider side of the business?
A. Depending upon the initiative.
Q. Who did the committee report to?
A. The committee reported to the new medical management model committee.
Q. The new management medical model?
A. New medical management model.
Q. Medical?
A. Yes. Acronym, NM3. I should say that is where I reported into.
Q. What is the new medical management model?
A. It is a committee of senior level individuals within the company that review major initiatives we're looking to implement.
Q. Who is on the committee?

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satisfaction levels that we negotiate with physicians in their contracts.
Q. All right.
A. There are measures in regards to management of, consistent with those quality programs, management of medical services within a defined parameter, financial parameter, and the opportunity for physicians to share in compensation for meeting those performance goals.
Q. You are referring to the primary care physician incentive program?
A. That's right.
Q. Previously --
A. Well, actually that is one program. The program I was referring to was a program we refer to as the GPIP program, which is the Group Physician Incentive Program.
Q. I am sorry. What was the name of that program?
A. It is GPIP, Group Physician Incentive Program.
Q. Is it fair to say that the overall

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level of compensation that a physician receives depends in part upon the achievement of the metrics set forth in these programs?
A. Correct.
Q. Now just at a very general level, is it that the physician receives more incentives if it meets the metrics, or is it that it receives less incentives than it would otherwise receive if it does not?
A. They receive more incentive if they meet the metrics.
Q. So it is an additional amount that they could shoot for on top of what they would otherwise be reimbursed?
A. That's correct.
Q. What --
MR. HAAS: Withdraw that question.
Q. Who was it that was responsible for the formation of the specialty pharmacy committee?
A. I was.
Q. Did the concept of the specialty pharmacy committee arise out of your

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participation and discussions in the special committee meetings that you held with the Massachusetts Society of Clinical Oncology?
A. No.
Q. Okay. Was that part of the rationale for putting together the specialty pharmacy committee?
A. No. Those meetings came after the formation of the specialty pharmacy committee.
Q. What is the oncology MASCO specialty committee?
A. I am sorry. I didn't get your question.
Q. What is the oncology MASCO specialty committee?
A. I am familiar with the Massachusetts Association of Clinical Oncologists or Massachusetts Society of Clinical Oncologists, MASCO.
Q. Yes.
A. My understanding is that is a committee of oncologists that meet. I'm not sure of the

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frequency of their meetings.
Q. Who is on the committee to your knowledge?
A. I don't know all of the members of the committee, but having participated in discussions with MASCO, Theresa Mulvey, who, I believe, is the president of MASCO; Dr. Wisch, who is an oncologist; Dr. Kagan, who is an oncologist; and I'm not familiar with the -- I am not recalling the other names of the oncologists that were part of that committee.
Q. And who participates in the specialty committee with MASCO on behalf of Blue Cross/Blue Shield of Massachusetts?
A. When you say specialty committee with MASCO, --
Q. Yes.
A. -- I am not familiar with what you are referring to.
MR. HAAS: Mark this.
(Two-page memorandum dated May 1, 2002, to Dr. Fanale from Dr. Cook,

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production numbers BCBSMA-AWP-0003 and 0004 marked Exhibit Killion 001 for identification.)

BY MR. HAAS:

Q. We are marking as Deposition Exhibit Killion 001 a document Bates stamped BCBSMA-AWP-0003 to 0004.

(Handing Exhibit Killion 001 to the witness.)

Q. This is a document dated May 1, 2002, from Jan Cook, M.D., to James Fanale, M.D., and you will see on the subject line it refers to Oncology, bracket, MASCO, Special Committee Minutes, April 29, 2002.

Do you see that?

A. Yes.

Q. Let me ask it this way. Are you familiar with a committee referred to as the oncology MASCO specialty committee?

A. No. I am familiar with MASCO. Although I am aware that Jan Cook had regular meetings with MASCO.

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Q. Were you aware that Jan Cook had regular meetings with other physician societies?

A. Yes.

Q. What other physician societies?

A. She participated in meetings with the Mass. Arthrometric Society, the Mass. Chiropractic Society, and a variety of other medical societies.

Q. Who is James Fanale, M.D.?

A. James Fanale was our chief medical officer.

Q. And Steve Fox was the director of provider relations?

A. That's correct.

Q. Who is Robert Mandel?

A. Robert Mandel I believe at the time was vice president for provider services.

Q. He is no longer with the company?

A. He left the company. He is now back with the company.

Q. What is his current position?

A. He is responsible for the

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transformation initiative.

Q. What is the transformation initiative?

A. It is an initiative where -- how best to describe the transformation initiative? It is a major initiative that Blue Cross/Blue Shield is looking at in regards to having an impact on how the -- the way in which healthcare is delivered within the Commonwealth of Massachusetts.

Q. And you say it is a major initiative to have impact. What does that mean?

A. It is a priority for our company in 2006 and beyond.

Q. I am trying to get an understanding of what the initiative is.

A. It is looking at a variety of different issues with the healthcare system and how we as a major player in the marketplace can be a leader in addressing a number of those issues.

Q. What are those issues?

A. The uninsured pool; quality; misuse of healthcare; underuse, overuse of healthcare; e-health initiatives related to medical records.

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Q. Do any of the initiatives involve reimbursement issues?

A. I'm not aware at this point specifically. The committee is just forming.

Q. Are you a member of that committee?

A. Not as of yet. Again the committee is just forming.

Q. To your understanding as of today, given its early phase, does the committee nevertheless have reimbursement for physician-administered drugs as part of its agenda?

A. I'm -- I'm not aware of one way or the other whether or not that is part of the overall agenda.

Q. So turning back to what we have marked as Deposition Exhibit Killion 001, when to your knowledge was the first time that you participated in any meeting of the MASCO specialty committee?

A. It would have been after we initiated the specialty pharmacy committee at Blue Cross/Blue Shield, which would have been, I

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believe, sometime in 2003.
Q. If you would look at that page, the second arrow in the middle talks about "multiple co-pays for cancer patients undergoing chemotherapy." For the record, it says, "MASCO doctors are concerned that payments may be foregoing chemotherapy in the office" --
MR. SULLIVAN: I think it said "patients."
MR. HAAS: Is that what I said? Let me read it again for the record so we are clear.
BY MR. HAAS:
Q. "MASCO's doctors are concerned that patients may be foregoing chemotherapy in the office set because of multiple co-pays," close quote.
And down at the bottom under "Action Item," it says, quote, "Robert to look into BCBSMA waiving co-pays for outpatient chemotherapy. Report back in one month."
Were you involved at all in any of your work at Blue Cross/Blue Shield in any initiatives

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designed to ensure that patients were administered drugs in physicians' offices rather than in the hospital?
A. No.
Q. Do you have any understanding of whether it was an agenda of Blue Cross/Blue Shield to encourage the administration of drugs in office versus in the hospital setting?
A. No.
Q. Are you aware of any studies or analyses of whether the costs of administering drugs in office is less to Blue Cross/Blue Shield of Massachusetts than administering drugs in the hospital setting?
A. Yes.
Q. What are you aware of?
A. That reimbursement in the hospital setting is a more expensive setting than in the physician office.
Q. That is something that Blue Cross/Blue Shield of Massachusetts studies or tracks?
A. It is something we have looked at.

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Q. In what context has Blue Cross/Blue Shield of Massachusetts looked at that?
A. In understanding an analysis, what our -- what our reimbursement is in the hospital setting versus the office setting.
Q. Were there studies done?
A. I can't say there were specific studies done, no.
Q. Were there cost analyses done?
A. I don't remember specific cost analyses that were done.
Q. What is the basis for your understanding that Blue Cross/Blue Shield of Massachusetts analyzed this?
A. I know we had looked at reimbursement specific to how hospitals were reimbursed for medications, not only oncology, but medications, versus how our reimbursement was structured in the physician setting.
Q. Did Blue Cross/Blue Shield have any programs or plans or initiatives designed to encourage the administration of drugs in office

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because it was cheaper to Blue Cross/Blue Shield of Massachusetts as well as the healthcare system as a whole?
A. No. Not that I'm aware of.
Q. What was the outcome of this analysis that you are aware of which concluded that it's less costly to administer the drugs in office than in the hospital setting?
A. The outcome of the analysis was looking at how we reimburse in the hospital setting and changing that reimbursement methodology.
Q. Were you aware of any programs that were put into place to waive the co-payments for patients in the in-office setting in order to encourage the administration of drugs in office?
A. No.
Q. Why is it that Jan Cook had these meetings with or has these meetings with these physician societies?
A. There are three regional medical directors. Each of them are assigned specific medical societies to work with and meet with.

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Massachusetts limit the drugs supplied through the specialty pharmacy vehicle to these four categories of drugs?
A. We haven't. We're continuing to pursue the specialty pharmacy initiative. A new RFP is going out, and we are looking at expanding the amount of medications that we include in the specialty pharmacy program beyond these drugs.
Q. Okay. Why to date has Blue Cross/Blue Shield of Massachusetts only contracted to supply for the supply of these four categories?
A. We have 2.8 million members. We wanted to stage the implementation of our specialty pharmacy program to make it a smooth transition for our members so that it was a successful implementation. So the decision was via the NM3 committee and the specialty pharmacy committee to make sure that we do it in a coordinated fashion without rolling out every individual initiative at all one time.
Q. All right.
A. So it is an ongoing initiative.

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Q. All right. How does the specialty pharmacy program work with respect to the supply of drugs to your members?
A. We contract directly with the specialty pharmacy -- well, I should say we contract through ESI, our pharmacy benefit management company, which contracts directly with the specialty pharmacy companies for the delivery of these medications at a discount. They supply the medications to our members and also provide clinical services to our members as far as phone calls, how is the member doing, what adverse reactions are they having, are they having problems with the medications, are they taking their medications on a routine basis, and so on.
Q. All right. Do the --
MR. HAAS: Withdraw that.
Q. In connection with this program, is it incumbent upon the members to bring the drugs to the doctors for administration?
A. Not necessarily.
Q. With respect to drugs that are

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physician- administered drugs, are those --
MR. HAAS: Well, withdraw that question.
Q. Does the specialty pharmacy program that Blue Cross/Blue Shield of Massachusetts implemented contemplate the supply of physician-administered drugs?
A. Yes.
Q. Okay. With respect to those drugs, the first question: Does the current structure now in place involve the supply of physician-administered drugs to the members of Blue Cross/Blue Shield?
A. The drugs that we contract for today are generally drugs that members have the ability to administer after training by the physician.
Q. Okay. Are there any drugs currently within the purview of the specialty pharmacy program that must be administered by a physician or under the supervision of a physician?
A. I think the answer to that is it depends upon the physician, but, no, the members

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can be trained to administer these drugs.
Q. Okay.
(The witness and Mr. Sullivan conferring off the record.)
BY MR. HAAS:
Q. Would you like to supplement your answer?
A. No.
Q. You said that the PBM supplies the drugs to the members at a discounted cost. What does that mean?
A. I didn't say the PBM supplied the drugs.
Q. I mean the PBM contracts to supply -- contracts with the specialty pharmacy to supply the drugs to the members at a discounted cost. When you say "discounted cost," what does that mean?
A. A discount off of what we were originally paying for those drugs, a steeper discount, anywhere from for hemophilia drugs up to a discount off of minus 40 percent off of AWP.

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Meeting marked Exhibit Killion 002 for identification.)

BY MR. HAAS:

Q. Marked as Deposition Exhibit Killion 002 is a document Bates stamped -- not Bates stamped -- it hasn't been produced to us with a Bates stamp -- titled "Blue Cross/Blue Shield of Massachusetts, Specialty Committee Meeting, Specialty Group, Massachusetts Society of Clinical Oncology, parenthetical, MSCO, date June 10, 2004.

(Handing Exhibit Killion 002 to the witness.)

Q. Mr. Killion, I ask that you take a look at this document and tell me if you recognize it; if so, what it is.

(Pause.)

(The witness viewing Exhibit Killion 002.)

A. I have read the document.

Q. What is it?

A. It is minutes that were in followup to

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a meeting that we had, Jan Cook and I from Blue Cross/Blue Shield, with the Mass. Society of Clinical Oncology discussing with them our -- two initiatives: one, our discussion around pay for performance and looking at quality cost program as well as a discussion with them in regards to our specialty pharmacy program.

Q. Were you involved at all in the discussions of whether to change the reimbursement methodology of Blue Cross/Blue Shield of Massachusetts from a fee-for-service amount based upon AWP or based upon Medicare to one based upon ASP?

A. I was involved in some of those discussions, yes.

Q. Were you involved in the determination of not to switch the methodology from an AWP-based methodology to an ASP-based methodology?

A. I was not involved in making that decision. I had comment in regards to that decision.

Q. What analysis did you do and commentary

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did you provide in connection thereto?

A. That at that point ASP was not industry standard, and that Blue Cross wanted to wait and further evaluate CMS's methodology before implementing an initiative with our oncologists that wasn't yet industry standard.

Q. Where is that documented?

A. I don't believe that it is documented.

Q. That was your input to the process, but you didn't document it in any way or form?

A. I had discussions.

Q. Who did you have discussions with?

A. Deb Devaux.

Q. Anyone else?

A. I had discussions with Jan Cook about that as well.

THE WITNESS: Can we take a five-minute break?

MR. HAAS: Sure.

(Recess taken at 11:32 a.m.)

(Recess ended at 11:39 a.m.)

MR. HAAS: Back on the record.

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BY MR. HAAS:

Q. You had mentioned that Blue Cross/Blue Shield had made the determination not to reduce reimbursement under the ASP methodology. Is it your understanding that the industry standard is to maintain reimbursement at 95 percent of AWP?

A. My understanding is not to -- the industry standard is not to move to ASP at this point in time.

Q. Right. My question is a little different. Is it your understanding that the industry standard is to maintain reimbursement at 95 percent of AWP?

A. For the most part, yes, that's correct.

Q. I have shown you what has been marked as Deposition Exhibit Killion 002, and I'm not sure if we have established the foundation, but what is this document?

A. It was a meeting that we had with MASCO. The date on it is June 10th of 2004. We are -- we had discussions with them on, well, two things in particular: specialty pharmacy as well

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formulary.
Q. And having determined that they were functionally equivalent, did they make a formulary decision based upon the economics of the administration of the drugs?
A. Yes. That went into the decision.
Q. To your knowledge is Blue Cross/Blue Shield of Massachusetts receiving any rebates on Gonal F or any other physician- administered drug?
A. Not to my knowledge.
Q. I started asking you before we switched topics what your litigation experience was, so let's get back to that. When have you been deposed previously?
A. I was deposed when I was at Harvard Pilgrim on two occasions.
Q. What was the nature of those depositions? What was the nature of the issue, the litigation that you were deposed concerning?
A. We had developed a relationship, a contract relationship, with a pharmacy for

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fertility medications. After I left Tufts, Blue Cross/Blue Shield terminated that relationship. The provider's assertion was that the agreement couldn't be terminated; it went into perpetuity.
MR. SULLIVAN: Excuse me. You said in your answer "Blue Cross/Blue Shield." Did you mean to say Tufts?
THE WITNESS: Tufts. I apologize.
BY MR. HAAS:
Q. Were those two depositions in connection with the same matter?
A. Yes.
Q. Have you been deposed in any other action?
A. No.
Q. Have you otherwise had any participation or involvement in any other litigation?
A. There was one incident at Tufts Health Plan.
Q. What was that incident?
A. It was in regards to a member who was

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trying to contact their primary care physician relative to OB services, was unable to contact their primary care physician. We outreached to the physician to contact the member. The physician apparently did not contact the member. The member had a bad experience and sued the physician.
Q. When you began in Blue Cross/Blue Shield of Massachusetts in 1985, did the company have in place a staff model at that time?
A. I don't recall.
(Discussion off the record.)
BY MR. HAAS:
Q. Getting back to what has been marked as Deposition Exhibit Killion 002, did you have any conversations or communications with any associations other than -- concerning the specialty pharmacy issue other than that that is reflected in this, the minutes of this meeting?
A. Other associations other than MASCO?
Q. Yes.
A. No.

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Q. Did you have subsequent communications with MASCO concerning this issue?
A. I was involved in more than one communication with MASCO. I'm not clear of the dates, so whether or not there were meetings prior to this meeting or after this meeting, I would need to see copies of minutes.
Q. But it is your recollection there were other specialty committee meetings with MASCO that involved the question of whether to implement a specialty pharmacy model for the supply of oncology drugs?
A. There were -- yes. There were other meetings with -- let me clarify that. Yes. There were other meetings with MASCO to discuss our specialty pharmacy program in general and any concerns or issues that MASCO wanted to raise in regards to the delivery of oncology medications.
Q. Were there any individuals on the specialty pharmacy committee that was specifically looking at the issue of whether to implement a specialty pharmacy model for oncology

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drugs?
A. We made the decision not to implement at that point in time and to further evaluate when we rolled out the specific therapeutic classes that I previously discussed.
Q. Okay. Now you said the decision was not to implement the model with respect to oncology drugs at that time. Why was that?
A. Part of it was because we were looking at CMS and the reimbursement methodology, understanding that at that point it wasn't industry standard. We were concerned, continue to be concerned, in regards to being overcharged for oncology medications but wanted to make sure we roll out a program that benefits our members and also addresses concerns that the oncologists have raised in a thoughtful manner.
Q. Okay. Who was involved in that analysis specifically dealing with oncology drugs?
A. Mike Mulrey was.
Q. Anyone else?

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A. Not that I'm aware of.
Q. Yesterday Mr. Mulrey testified the only involvement he had was implementing your strategy. Is that incorrect testimony?
A. Mike Mulrey had done an analysis looking at the impact of moving to AWP minus 15.
Q. Right. But right now I'm talking about whether the -- whether Blue Cross/Blue Shield of Massachusetts --
MR. HAAS: Withdraw that question.
Q. The issue we're addressing, talking about now is Blue Cross/Blue Shield's decision to defer implementing the specialty pharmacy model for oncology drugs.
A. Um-hmm.
Q. So the question, number one, is what involvement, if any, did Mike Mulrey have in that decision-making process?
A. When you say implementing oncology for specialty pharmacy, do you mean utilizing a specialty pharmacy vendor for the oncology program?

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Q. Yes.
A. We didn't contemplate doing that. We contemplated looking at a change in reimbursement methodology to our oncologists but not implementing a specialty pharmacy program at that point in time.
Q. All right. I understand that Blue Cross/Blue Shield of Massachusetts engaged in an analysis of whether to move from AWP or fee schedule based methodology to ASP. I understand that.
A. And that is Mike Mulrey's analysis that I refer to.
Q. Aside from that, with respect to the question of whether or not Blue Cross/Blue Shield of Massachusetts contemplated implementing a specialty pharmacy model for the supply and administration of oncology drugs, question number one, did Blue Cross/Blue Shield of Massachusetts contemplate implementing a specialty pharmacy model for oncology drugs?
A. We deferred a decision to implement

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until we had more time to evaluate CMS methodology.
Q. Okay. CMS doesn't have a specialty pharmacy reimbursement model, does it?
A. CMS has a reimbursement model. When you -- when you mean specialty pharmacy, do they use a specialty pharmacy vendor to --
Q. Right.
A. Not that I'm aware of. I believe it is something that CMS is looking at.
Q. My immediate question, though, is what Blue Cross/Blue Shield considered in 2004. Did Blue Cross/Blue Shield of Massachusetts give any consideration, do any analysis of whether to implement a specialty pharmacy model with respect to oncology drugs at that time?
A. No. We decided to defer.
Q. Did you decide to defer the analysis or the decision?
A. The decision as to when we would implement the program.
Q. Okay. So let me move back to my

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AWP was set, if you had any understanding?
A. That the manufacturers had a lot of involvement in regards to AWP.
Q. My question is what was your understanding as to how -- I understand your position in this litigation, but my specific question was what was your understanding as to how AWP was calculated.
MR. SULLIVAN: That is a different question.
MR. HAAS: Well, it is not. What I said was "set."
BY MR. HAAS:
Q. But go ahead.
A. That it -- again that it was -- it was a fee that was established for the price of drugs and that manufacturers had a large role in dictating what that fee was.
Q. How did you determine that manufacturers had a large role in determining what that fee was?
A. That was my understanding.

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Q. How did you get that understanding?
A. In -- in working in retail pharmacy at that time.
Q. What communication did you have that reinforced or established that understanding at that time?
A. I think there were discussions internally within the company in regards to AWP and people referring to AWP as a -- as an artificial price but a price that the industry used in regards to establishing reimbursement off of.
Q. So when you were working in retail pharmacy, you understood that AWP was an artificial term, an artificial price?
A. Yes. That it was a -- correct.
Q. Okay. And you had discussions with other members of Blue Cross/Blue Shield at that time?
MR. SKWARA: Objection.
Q. Right?
A. That was Tufts Health Plan.

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Q. Excuse me. You had discussions with other individuals at Tufts Health Plan at that time regarding the fact that AWP was an artificial price; correct?
MR. SULLIVAN: Objection. Beyond the scope.
Q. You can answer.
A. We had concerns at Tufts Health Plan in regards to AWP, although we used AWP as the price in which we reimbursed for drugs at the retail pharmacy and encouraged our physicians to utilize generics.
Q. And what were your concerns with the use of AWP at that time given that you knew that it was an artificial price?
A. Well, one of our major initiatives was to move physicians to generic medications, knowing that they were much more cost effective than the price that was set for brand medications.
Q. So what did your knowledge that AWP was an artificial price have to do with that

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initiative?
A. Moving physicians to generic medications produced the result of providing a more cost effective retail pharmacy program.
Q. That is because you understood at the time that generic drugs were discounted much more heavily than brand name drugs; right?
A. That's right.
Q. That is common knowledge in the industry; right?
A. Maximum allowable cost.
Q. Well, my question is isn't it common knowledge or wasn't it common knowledge --
A. Yes, it was.
Q. -- at the time frame in 1998 when you were in the retail pharmacy department of Tufts that generic drugs were discounted heavily as compared to brand name drugs?
A. Yes.
MR. SULLIVAN: Objection. Beyond the scope.
A. Yes. That was my knowledge.

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Q. Was it also your understanding at the time that when competition came into the market for brand name drugs, i.e., multisource competition, there were also discounts and rebates that were provided on those drugs?
MR. SULLIVAN: Objection. Beyond the scope.
A. That's correct.
Q. So typically -- so it was your understanding then in the 1998 time frame that when a brand name drug first came to market there typically were no incentives associated with the drug, but then as competition entered the market, first multisource, and then with generics, more incentives were provided for the drug; correct?
MR. SULLIVAN: Objection.
A. Correct.
Q. And that is what led to your understanding that AWP was an artificial price because it didn't bear a relationship to the acquisition cost; correct?
A. Correct.

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Q. Now in 1998 when you had this understanding, how did that impact the reimbursement policies of Tufts at this time?
MR. SULLIVAN: Objection. Beyond the scope.
A. Tufts put in place a pharmacy risk program to encourage the utilization of generic medications and formulary medications at this point in time.
Q. And what was the reimbursement methodologies that Tufts put in place in order to address its understanding that generic drugs were cheaper?
A. Can you repeat that question?
Q. I am just trying to close a loop. What was the particular pharmacy risk program that Tufts put into place?
A. I am sorry. Your question was what was the particular pharmacy risk program that Tufts put into place?
Q. Yes. You had testified that Tufts put into place a pharmacy risk program.

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A. That's correct.
Q. My question simply is what was that program.
A. As I stated before, Tufts had a budget per IPA, PHO, in regards to pharmacy expense, provided reports to physicians in regards to generic brand name utilization and encouraged the use of generic utilization in our network along with formulary utilization and other preferred plans that we put in place where there was prior authorization for high-cost brand name drugs.
Q. Now we were discussing your knowledge while at Tufts in 1998 that acquisition costs varied based upon the competition for the drugs in the marketplace. When did you first obtain that understanding?
MR. SULLIVAN: Objection. I think that mischaracterizes what the witness' testimony was.
MR. HAAS: I disagree.
BY MR. HAAS:
Q. But you can clarify.
MR. SULLIVAN: Do you understand the question?

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THE WITNESS: No.
Q. My question is when did you first obtain the understanding that you have testified to that in 1998 you understood that the acquisition cost of drugs varied depending upon whether it was branded, multisource or generic, and the level of competition in the marketplace?
A. Through our PBM and the discounts that we were able to achieve through multisource drugs versus brand name drugs --
Q. All right.
A. -- and the competition in the marketplace.
Q. All right. Did you have that understanding before coming to Tufts or while working at Tufts?
A. While working in Tufts.
Q. So you obtained that understanding in the 1998 time frame?
A. Correct.
Q. Was it your understanding that that was

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A. My understanding of, again, of AWP as it relates to acquisition cost.
Q. As you testified in the record prior to the break?
A. That's correct.
MR. HAAS: I have no further questions at this time.
MR. NOTARGIACOMO: In general or about that subject? Your examination is concluded?
MR. HAAS: It is concluded at this time.
MR. NOTARGIACOMO: I just have a few, a very few questions in --
MR. HAAS: You are providing the cross on behalf of plaintiffs?
MR. SULLIVAN: Yes.
MR. NOTARGIACOMO: Yes.
MR. HAAS: Okay.
CROSS EXAMINATION
BY MR. NOTARGIACOMO:
Q. When you -- do you remember when you were discussing with Attorney Haas your

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employment at Tufts Healthcare prior to the break?
A. Yes.
Q. And there was a discussion about average wholesale price and its relationship to the actual acquisition prices; do you recall that?
MR. HAAS: Objection --
A. Yes.
MR. HAAS: -- to form.
Q. And Mr. Haas asked you about your use or -- he asked you about your understanding about what AWP was?
MR. HAAS: Objection to form.
Q. Do you recall that?
A. I do.
Q. And do you recall saying that AWP was an artificial price?
MR. HAAS: Objection to form.
A. I do.
Q. And prior to the break, Mr. Haas asked you -- Attorney Haas asked you whether it was

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your understanding that AWP was an artificial price because it did not bear a relationship to actual prices. Do you remember agreeing to that statement?
MR. HAAS: Objection to form.
A. I do.
Q. Do you have an understanding -- well, actually in 1998 when you were employed at Tufts, do you have an understanding of how AWP was calculated?
MR. HAAS: Objection to form.
A. No. Not how it was calculated.
Q. Do you have -- did you have an understanding as to the relationship between AWP and the actual prices that were paid by physicians for physician- administered drugs?
A. No.
MR. HAAS: Objection to form. The record speaks for itself.
Q. When you said and used the term "artificial price" in that answer, what did you mean by the term "artificial price"?

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MR. HAAS: Objection to form.
A. Artificial price meaning a -- a price that -- that was referred to as it ain't what you pay, or the acronym AWP, ain't what you pay, used commonly at Tufts Health Plan.
Q. Did you have an understanding -- are you using that term, "it ain't what it pays," is it your understanding that AWP was not the arithmetic actual average of wholesale prices?
A. That --
MR. HAAS: Objection to form. Leading question.
A. That's correct.
Q. Did you understand what the relationship was between average wholesale price and as published or as --
MR. NOTARGIACOMO: Strike that.
Q. Did you have an understanding about what average wholesale price was in relationship to the prices that physicians were paying for those drugs?
A. No, I did not.

MR. HAAS: Objection to form. The record speaks for itself.
MR. NOTARGIACOMO: I have no further questions.
REDIRECT EXAMINATION
BY MR. HAAS:
Q. Just to clarify, you testified after the break following your conversations with counsel that it was commonly discussed at Tufts Plan in the 1998 time frame that AWP properly stood for "ain't what's paid"; is that correct?
MR. SULLIVAN: Objection. Form.
A. That term had been used. Correct.
Q. And I believe you just testified that you had --
MR. HAAS: I withdraw that question.
Q. So you understood that by that phrase, "ain't what's paid," that AWP was not in fact the actual average of wholesale prices; correct?
A. That's correct.
Q. And you understood at this time and it was discussed at Tufts that AWP bore no



predictable relationship to the actual cost as paid; right?
MR. SULLIVAN: Objection to form; compound.
A. Correct.
Q. Okay.
MR. HAAS: I have no further questions.
MR. NOTARGIACOMO: I think we are done.
MR. SULLIVAN: Okay. Thank you.
(Whereupon, at 1:13 p.m., the deposition was adjourned.)

_____
JOHN M. KILLION
Subscribed and sworn to and before me
this _____ day of _____, 20____.

_____
Notary Public



CERTIFICATE
Commonwealth of Massachusetts
Plymouth, ss.
I, Judith McGovern Williams, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify:
That JOHN M. KILLION, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the said witness.
IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 2006.

Judith McGovern Williams
Registered Professional Reporter
Certified Realtime Reporter
Certified LiveNote Reporter
Certified Shorthand Reporter No. 130993

My Commission expires:
April 2, 2010

# EXHIBIT 8

IN THE DISTRICT OF MASSACHUSETTS

-O-

IN RE: :

PHARMACEUTICAL INDUSTRY MDL No. 1456

AVERAGE WHOLESALE PRICE : 01-CV-1225

LITIGATION

30(b)(6) DEPOSITION OF: IHC HEALTH PLANS

ERIC CANNON

-O-

Place: IHC Health Plans
4646 West Lake Park Blvd.
Salt Lake City, Utah 84120

Date: September 13, 2004
9:40 a.m.

Reporter: Vickie Larsen, CSR/RPR

-O-

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Q. And did the prices paid to providers for prescription drugs ever changed as a result of these informal discussions?
A. Yes, they did.
Q. Are you aware of any specific examples where prices changed?
A. I cannot think of any specific examples.
Q. Were prices usually decreased as a result of the discussions?
A. As many times as prices were decreased I would imagine we also increased them. It goes both ways.
Q. Okay. In your current job as the director of pharmacy services is it important to you to keep up to date on prescription drug pricing issues?
A. Yes, it is.
Q. And what do you do to keep up to date on those issues?
A. In order to keep up to date on pricing issues we first of all load into our system on a weekly basis databases from either First Data Bank or

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Medispan that include pricing information. We talk with vendors about pricing changes, price increases. We receive from manufacturers notification when prices are raised.

We track closely the number of manufacturers that may be selling a generic product that would indicate price competition in a specific category. We monitor communications that may take place through newsletter groups or journal articles or internet or wherever information -- wherever we can find information, we'll take it.

Q. One of the things that you mentioned is that you keep track of the number of companies selling generic products?
A. Yes.
Q. Why is the number of companies selling a generic product important?
A. The number of companies selling a generic product is important to us in that as the number of companies selling a particular product increases, so does competition. Generally speaking as price or as competition increases within a category, the price

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then begins to drop.
Q. Are you familiar with the term "AWP" or "average wholesale price" in the context of prescription drugs?
A. Yes, I am.
Q. And you mentioned that you subscribe to First Data Bank and/or Medispan databases; is that correct?
A. Yes.
Q. Are AWPs published in those?
A. Yes.
Q. Are AWPs for generic products also published?
A. Yes.
Q. In your experience does the AWP for a generic product tend to decrease when additional sellers of generic products enter the market?
A. No, it does not.
MR. EVERETT: Let's go off the record.
(There was a break taken.)
MR. EVERETT: Let's go back on the record.

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Q. When we went off the record we were talking about things that you do as director of pharmacy to keep up to date on drug pricing issues. And you mentioned that you read a newsletter groups and journal articles. What newsletter groups does IHC Health Plan subscribe to or receive?
A. We receive The Pink Sheet. We get a newsletter called Generic Line. We belong to a group that provides updates on injectable pricing called R.J. Health. They provide a newsletter, the title of which I'm unaware.
Q. Okay. What other periodicals?
A. Those are the main periodicals I can think of.
Q. Okay. What is The Pink Sheet?
A. The Pink Sheet is a -- it's fairly big and I'm not sure who the publisher is -- but it provides updates on issues as they go through the FDA or other issues as it relates to pharmaceuticals.
Q. You also mentioned that you subscribe to First Data Bank and/or Medispan for the pricing. Are there any other industry pricing compendia?

# EXHIBIT 9

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

No. 01CV12257-PBS

**********

IN RE: PHARMACEUTICAL INDUSTRY *
AVERAGE WHOLESALE PRICE LITIGATION *

**********

DEPOSITION OF JILL S. HERBOLD, taken pursuant to the Federal Rules of Civil Procedure, at CIGNA Headquarters, 900 Cottage Grove Road, South Building, Bloomfield, CT, before Diana M. Noel, a Registered Professional Reporter, Certified Realtime Reporter, and Licensed Shorthand Reporter No. 199, in and for the State of Connecticut, on Friday, January 14, 2005, commencing at 12:48 PM.

acquisition costs?
A. Yes.
Q. And what is your understanding of that term?
A. That it is -- it represents a rate amount that is supposed to be the wholesaler's acquisition cost, but exactly how it all gets calculated, I do not know. What I do know about it is that it -- every situation -- I've never known it to be above AWP, so less than AWP, but exactly what the number is doesn't have a direct relationship with AWP.
Q. Would you say that Cigna has an understanding that providers need to make a profit margin in order to stay in business?
MR. ST. PHILLIP: Objection.
A. Your question was if providers need a profit margin to stay in business?
Q. Is that correct?
A. Yes.
Q. And that as a general matter, Cigna assumes that the reimbursement rates that it provides providers will allow the physicians to make a fair and reasonable margin and stay in business; isn't that correct?



MR. ST. PHILLIP: Objection.
THE WITNESS: Could you repeat the question.
(The court reporter read back.)
A. The reimbursement to the providers is the result of the negotiations, and while as we cannot determine if that reimbursement will allow us -- will allow the provider to make a profit or not, it is in Cigna's interest that providers do stay in business, because they are the ones that are servicing our members.
Q. Does Cigna have a preference for the site that a physician administered drug is administered?
MR. ST. PHILLIP: I'm sorry, can you read that back.
(The court reporter read back.)
A. To my knowledge, no. The -- we want doctors following standard medical protocols, but I do not know of a specific statement of any sort related to that matter.
Q. For example, if a particular drug could be administered in a physician's office but could also be



administered in a hospital outpatient department, does Cigna have any preference over the site of care?
MR. ST. PHILLIP: Objection, insofar as it calls for an across the board answer. Go ahead.
A. The answer to that is that our preference, if it was medically appropriate to do so, for that injectable to be administered in a physician's office because it generally is better for the member as well as the lower medical costs.
Q. And do you know why there are lower medical costs in a physician's office as opposed to a hospital outpatient department?
A. That would be because of the overhead and facility costs that is associated with the outpatient facilities.
Q. So Cigna's reimbursement to the hospital would generally be greater than its reimbursement to a physician's office for administration of the same product?
MR. ST. PHILLIP: I'm going to object.
Q. Is that correct?



MR. ST. PHILLIP: The court excluded deposition topic No. 18 which reads, whether and to what extent you provide different reimbursement rates for subject drugs when they are administered in providers' offices rather than in hospitals, including your clients' rationale for doing so or not doing so. The Magistrate Judge excluded that testimony, so I instruct the witness not to answer.
MS. SCHOEN: Well, clearly we disagree and feel that this deposition topic falls under other areas.
For purposes of moving forward today, we will move forward.
Q. Do you have any knowledge that doctors have conspired with drug manufacturers to inflate drugs' average wholesale price?
MR. ST. PHILLIP: Object insofar as it calls for a legal conclusion, but you can answer.
A. I have no knowledge.

have knowledge of that period, is it your testimony that Cigna reimburses the physician at a rate, a negotiated rate, but a rate that was a percentage off of -- expressed as a percentage off of average wholesale price or AWP, is that correct?

MS. SCHOEN: Objection to form.

MR. ST. PHILLIP: If you could do that one more time, we just increased in volume so we'll be able to do it.

Q. Sticking with the period from 2002 earlier, I'm basing your conversations with people at Cigna, was it your testimony today that Cigna reimburses physicians or reimbursed physicians at a price that was a discount off of average wholesale price?

MS. SCHOEN: Objection to form.

Q. Is that correct?

A. Prior to 2002, Cigna reimbursed physicians at the negotiated rates. Those negotiated rates were commonly expressed as percent of AWP. They may have also been expressed as a percent of billed charges, but those are the only two approaches that I'm aware of.

Q. And then for the period from 2002 on, you



said that approximately 50 percent of reimbursement is done at or under that same methodology as a negotiated price off of the average wholesale price or as a percentage of bill charged; is that correct?

A. That is correct.

Q. And the other 50 percent is based on Cigna's national standard pricing list, is that correct?

A. Yes, that is correct.

Q. And even the prices on Cigna's national standard pricing list are expressed as a percentage off of average wholesale price, is that correct?

A. Yes, some of them are. Not all of them are.

Q. Some of them are.

The ones that aren't, are you referring specifically to the 13 -- the drugs that fall under the 13 codes that are based --

A. Yes.

Q. -- on something different?

A. Yes.

Q. And those exceptions, those 13 codes, the reimbursement methodology for those drugs is based on acquisition costs, but isn't it true that it also has a



part of the formula that is also based on average wholesale price, is that correct?

A. That is correct.

Q. Would you agree with me that Cigna's goal is to get the best -- when negotiating with physicians about the reimbursement for physician administered drugs, would you agree that Cigna's goal is to get the best deal it can for itself while providing adequate reimbursement to physicians for the drugs it administers to its members?

A. Yes.

Q. And is it fair to say that Cigna expects that the doctors in its network to make a living primarily providing treatment to patients and not from large markups on those physician administered drugs?

MS. SCHOEN: Objection to form.

A. Could you please repeat the question.

Q. Sure.

Is it fair to say that Cigna expects that doctors in its networks are -- make their living primarily providing treatment to patients and the payment from providing treatment to patients and not



from large markups on prescription drugs that it administers?

MS. SCHOEN: Objection to form.

A. With respect to the reimbursement of practitioners for their services, we expect that the physician is negotiating with us and another carrier so that they can maintain sufficient profit margin to operate their business and stay in business. We don't have a specific expectation about exactly what their billed charges might be for a particular service because it's a difference between that billed charge and the reimbursement amount that I would call and refer to as a markup.

Q. When you use the term billed charge, what are you referring to?

A. What I'm referring to there is the fee amount that the physician would submit on the claim in order for the claim to get paid. It's -- another way to say it is it is the amount that the physician would charge for an indemnity member.

Q. Let's turn back to the 13 codes that we talked about a few minutes ago.

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I believe you testified that one -- and correct me if I'm wrong -- that the reason that Cigna singled out these 13 codes for different treatment was the fact that there became available on the market generic forms of those drugs that were available at a cheaper price, is that accurate?

A. Yes, and let me clarify. Our change that we made was in reaction to the result of competitive market forces. Generic drugs were introduced that drove down the acquisition cost, the cost of the product in the marketplace.

Q. And the change -- were you finished?

A. Yes -- I'm finished, yes.

Q. And the change in the reimbursement for those codes that Cigna instituted, was that an attempt to bring physician reimbursements for those codes in line with the lower price available in the marketplace for those drugs?

A. Yes.

Q. So if Cigna had information that other drugs other than that 13 were available for a price that was significantly less than the reimbursement that Cigna

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currently provides in its national standard price list, would Cigna take steps to try to bring the reimbursement rate that it provides down to the level that's available -- the level of reimbursement that's available to doctors who purchase in the marketplace?

MS. SCHOEN: Objection to form.

A. Cigna is trying to make sure that we maintain -- well, that we have competitive medical costs that we are able to sell our products and have members, and Cigna is -- also has an interest, as I've stated, in making sure that the providers can stay in business.

And in terms of applying that to the reimbursement for specific drugs, we made those changes reflecting the changes that were going on in the marketplace, and also what physicians were willing to accept for reimbursement.

I mean, another way of thinking about that is that we ranked the changes that we're aware of in terms of market price changes, but it also -- we have to factor in what is the reimbursement amount that physicians are willing to accept.

Q. You testified that -- when you were asked

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whether Cigna understands what physicians paid for physician administered drugs, you just testified that Cigna didn't have an understanding of that.

Is that generally your testimony?

A. We don't have specific knowledge about it. The knowledge that we have is just based on what -- it's really based on we set a fee amount, and the providers come back and complain about it or they don't. So it's not that we understand their specific acquisition costs, but if our reimbursement is too low, we hear about it.

Q. I think you testified that one of the exceptions is some -- with respect to some manufacturers of immunization products.

Do you remember testifying about that?

A. I'm sorry, can you please repeat that question?

Q. Sure.

I think that you testified with respect to having had some contact with some manufacturers of immunization products?

A. Yes.

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Q. And in that way learning what the physician acquisition price for immunization products -- at least some products are; is that accurate?

A. That is accurate. My prior comment was related to injectables. I'm sorry, I didn't clarify that.

Q. That's okay.

As with respect to the immunization products and the information that Cigna obtained with respect to those conversations, did that information then -- was that used by Cigna in determining what reimbursement it would provide to physicians for those immunization products?

A. That's a very interesting question. As I mentioned, it is in the recent past, and to be more specific, the last month and a half, that we have gotten that information, and we have yet to make a determination about exactly how we're going to set our reimbursement on immunizations going forward.

MR. NOTARGIACOMO: I have no other questions.

MR. ST. PHILLIP: I have none.

# EXHIBIT 10

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
NO. 01CV12257-PBS

In re: PHARMACEUTICAL )
INDUSTRY AVERAGE WHOLESALE )
PRICE LITIGATION )
)
THIS DOCUMENT RELATES TO: )
ALL ACTIONS )
)

DEPOSITION of HARVARD PILGRIM HEALTH CARE BY JAMES T. KENNEY, called as a witness by and on behalf of the Defendants, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, Rule 30 (b)(6), before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Harvard Pilgrim Health Care, 93 Worcester Road, Wellesley, Massachusetts, on Monday, 20 September, 2004, commencing at 10:50 a.m.

physician clinics that provide services to the Harvard Pilgrim members, is that correct?
A. Yes.
Q. How did Harvard acquire the drugs that were dispensed in its pharmacies through the staff model HMO?
MR. HORGAN: Objection.
A. It purchased them either direct from a manufacturer or through a wholesaler.
Q. Similarly, with respect to the drugs dispensed -- withdraw that question. With respect to the drugs administered in physicians' offices, how did Harvard acquire those drugs --
MR. HORGAN: Objection.
Q. -- through the staff model HMO?
A. Same, either direct or through the wholesaler.
Q. Were you involved at all in the contracting or negotiation for the purchase of drugs from either manufacturers or wholesalers for the staff model HMO?
A. Yes.



Q. And what was your involvement?
A. My role was to negotiate contracts with those manufacturers that -- how do I phrase it? We didn't really have a central function. So, each pharmacy negotiated a few contracts.
Q. Uh-huh.
A. That's kind of how it worked.
Q. How many pharmacies were -- made up the network of the staff model HMO?
A. At that time, I believe it was nine.
Q. So, is it correct that in your role over the years as -- in the various pharmacy roles for your staff model HMO, you negotiated purchase contracts with manufacturers for the drugs dispensed through the pharmacy?
A. In my role at the staff model, yes.
Q. To your recollection, were the prices for the drugs that Harvard purchased from manufacturers set based upon any particular benchmark?
MR. HORGAN: During the staff model HMO?
MR. HAAS: Yes.
A. I would say the benchmark was WAC.



Q. Uh-huh. And to your recollection, what was the range of percentages markup or discount off of WAC at which Harvard acquired drugs from manufacturers for dispensing through its staff model HMO pharmacists?
MR. HORGAN: Objection. You can answer.
A. 2 percent, to maybe 50, 60 percent.
Q. Above or below WAC?
MR. HORGAN: Objection.
A. Below WAC.
Q. With respect to brand name drugs -- let's stick with brand name drugs for a moment. What was the percentage markup or discount off of WAC that Harvard Pilgrim acquired drugs from manufacturers for its staff model HMO?
MR. HORGAN: Objection. Can you -- all these are just if you know, all these questions.
A. The branded discount was 2 to 50 percent.
Q. 2 percent to 50 percent.
A. 2 to 50 percent off.
Q. Did the discounts off of WAC differ with respect to generic drugs that Harvard purchased on



behalf of its staff model HMO?
A. Yes.
Q. What were the discounts off of WAC that Harvard Pilgrim received with respect to the general risk purchased from manufacturers for its staff model HMO?
A. 50 percent to 80 percent.
Q. At that time did Harvard negotiate separate manufacturer rebate agreements with manufacturers for the drugs that were dispensed or administered by the staff model HMO?
A. No.
Q. Were the rebate -- withdraw that question. Were the discounts off of WAC at which Harvard acquired drugs from manufacturers inclusive of a rebate that pertained to the drugs that were dispensed or administered by the pharmacies --
MR. HORGAN: Objection.
Q. -- or the clinics?
MR. HORGAN: Objection.
A. No.
Q. Was it your understanding that at the time

that you were negotiating these prices with manufacturers for drugs for the staff model HMO that Harvard Pilgrim was getting a particularly good price from the manufacturers that wasn't otherwise available in the marketplace?
MR. HORGAN: Objection.
A. No.
Q. So, to your understanding at the time, any pharmacy could obtain drugs at between 2 percent to 50 percent or 60 percent off for brand name drugs from manufacturers, is that correct?
MR. HORGAN: Objection.
A. I don't know.
Q. Was that your understanding at the time?
A. I don't know.
MR. NALVEN: Objection.
A. I don't know what any other pharmacies were paying.
Q. With respect to the drugs acquired from wholesalers, was the price for the drugs that Harvard Pilgrim purchased from wholesalers for the staff model HMO based on any particular benchmark?



A. WAC.
Q. Uh-huh. What was the range of discounts off of WAC or above WAC at which Harvard acquired brand name drugs from wholesalers?
A. WAC plus 2 percent.
Q. What was the discount above or below WAC at which Harvard acquired generic drugs from wholesalers for its staff model HMO?
A. 50 to 80 percent.
Q. Off WAC?
A. Uh-huh.
Q. And again, was it your understanding at the time that those were market prices that otherwise would be available in the industry?
MR. NALVEN: Objection.
MR. HORGAN: Objection.
A. Yes.
Q. When you were negotiating with manufacturers and wholesalers for the purchase of drugs on behalf of staff model HMO, what was your understanding of the term "WAC" or wholesale acquisition cost?



A. The price that the manufacturer charged the wholesaler.
Q. Did you have an understanding at the time whether or not that price was published in any industry compendia?
A. No.
MR. NALVEN: Object to the form on that last question, please.
Q. With respect to tracking drug costs or reimbursement internally at the staff model HMO, did Harvard Pilgrim track the drugs that were dispensed to its members based upon a benchmark or at a cost amount, to your knowledge?
MR. HORGAN: Objection.
A. Cost.
Q. Did there come a point in time that you became involved in the negotiation of rebates for manufacturers?
A. Yes.
Q. When was that?
A. 1988.
Q. What was your involvement at that time?



A. My role was to establish a rebate program -- or rebate contracts for Harvard Community Health Plan.
Q. Prior to 1988, did Harvard Community Health Plan have any rebate program with manufacturers?
MR. HORGAN: Objection.
A. No.
Q. To your knowledge, prior to 1998, did Harvard Community Health Plan receive any rebates through its contract with any pharmacy benefit manager?
A. I don't know.
Q. Uh-huh.
A. I'm sorry. PBM, no.
Q. At any point in time while you were at Harvard Community Health Plan, did Harvard Community contract with a PBM for the administration of its pharmacy benefit?
A. Could you repeat that question, please.
Q. Yeah. At any time that you worked for Harvard Pilgrim, has Harvard Pilgrim contracted